Buried in Center Creek Cemetery

Who:	Pad	FGS
John Bunyon Rooker & Mary Eliz. Smith		✓
Benj Cluff Sr & (2) Eliza Arent Foster		✓
(1) Mary Ellen Foster		
Lucy Cluff * 30 Sep 1875 F=Benj		
† 30 Sep 1875 (2) Eliza A Foster		
Hammond A Havrican		
Tom Cole & Rebecca R Cole		
Samuel McRae Rooker		✓
Permilia Emily Woolridge Rookers		
Jens N Miller		
Anna M Miller		
Tom Reloy Cole & Lucynthia Rebecca Rooker		

FOR STATE USE ONLY

PHYSICIAN INVOICE

UTAH DEPARTMENT OF SOCIAL SERVICES

Mail Claim To:
Medical Claims Section
Dept. Of Social Services
Box 2500
Salt Lake City, Utah 84111
Phone 533-6571

XIX-P-1
Rev. 3/76

1. Patient's Last Name	2. First Name	3. MI	4. Age	5. Sex	6. Patient's Address and Zip Code
LEWIS	Ruth	A	21	F	P.O. Box 409 Heber City, Utah 84032

7. Client ID Number	8. Expiration date of ID Card
20650-69523	8-31-78

9. Provider Name and Address	10. Provider No.	11. Medical Record No.	13. Indicate if Special Type of Service	14. If Anesthesiology Claim, Enter Number of Minutes
R. R. Green, MD 45 S Main St Heber, Ut 84032 Phone: 654-1822	108448		☐ A. Anesthesiology ☐ B. Assistant at Surgery ☐ C. Professional Component	

12. Date Patient first consulted you for this condition: 8-4-78

15. (A) Primary Diagnosis, Problem or Injury: Traumatic injury to L great toe — 16. (A) H-ICDA Code

(B) Secondary Diagnosis — (B) H-ICDA Code

(C) Tertiary Diagnosis — (C) H-ICDA Code

(D) Quarternary Diagnosis — (D) H-ICDA Code

17. If this condition required a prior authorization, enter the prior authorization number:

18. If patient was a referral, enter name of referring practitioner:

19. Provider No.

20. Does patient have health insurance other than Medicaid? A ☐ Yes B ☒ No

21. If yes, enter patient's health insurance policy number

22. If patient has health insurance, give insurance company name and address

23. Was patient involved in accident? A ☐ Yes B ☒ No

SERVICES RENDERED:

24. Line No.	NOTE: Use line 1 to describe hospital visits only. 25. Dates of Service From (mo day yr)	Thru (mo day yr)	26. Procedure (USMA Code Accepted)	27. Number Visits	28. Family Planning? (1)	29. Place of Service (2)	30. Diagnosis Treated (3)	31. Charge	32. (Leave Blank)
1			(HOSPITAL SERVICES ONLY) 902 ___						
2	8 4 78		Office Call & Examination 90050			1	A	10.00	
3									
4									
5									
6									
7									
8									

(1) Family Planning: If the service provided was for family planning purposes, enter "Y"

(2) Place of Service Codes: 1 Office; 2 Patient's Home; 3 Inpatient Hospital; 4 Outpatient Hospital; 5 Clinic; 6 Skilled Nursing Facility; 7 Intermediate Care Facility; 8 Other

(3) Diagnosis Treated, Enter: 'A' if Primary; 'B' if Secondary; 'C' if Tertiary; 'D' if Quarternary; 'E' if Combination

33. TOTAL CHARGE	10.00	
34. Less Amount Received from Other Sources	XXXXX	36. Billing Date (mo/day/yr)
35. NET CHARGE	10.00	8-18-78

PROVIDER CERTIFICATION I certify that: (1) The services on this statement were rendered in behalf of the patient named herein; that this claim constitutes the full and complete charge for services described above; that I will make no further claim for payment of this service; that these services have been provided without discrimination based upon race, color, sex, creed, or national origin; (2) The information I have provided on this form is true, accurate, and complete. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under Utah's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State agency may request. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal or State laws.

AUTHORIZED SIGNATURE _____